

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04317

832

253

1. PLACE OF DEATH:

County..... New Anne
 City or town..... Stevensville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... all her life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... New Anne
 City or town..... Stevensville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

Clara Sidney Bullen

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Samuel Richard Bullen
 6.(c) If alive, give age..... 65 years
 7. Birth date of deceased (mo., day, yr.)..... Sept 6 - 1896

8. AGE: Years..... 50 Months..... 8 Days..... 19 If less than one day..... hrs. min.

9. Birthplace..... Stevensville, Md
 (Town, county, and state)

10. Usual occupation..... Home life

11. Industry or business

12. Name..... William Grimes
 13. Birthplace..... Trent, Del - Md
 14. Maiden name..... Emma Frances
 15. Birthplace..... Stevensville, Md

16. Informant..... Samuel Richard Bullen
 Address..... Stevensville, Md

17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... May 29
 (month) (day) (year)

Cemetery or crematory..... Stevensville
 Location..... Stevensville - Md

18. Funeral director..... Burtin Bros
 Address..... Centerville, Md

19. May 30 1947 Elizabeth Foster
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 27 1947 at 2 9 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1947 to May 27 1947.
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Cerebral embolism +
thrombosis

Due to.....

Arterio sclerosis
(cerebral)

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Theodor Sattelmair M.D. M. D. or other

Address..... Stevensville Date signed..... 5/27/47

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JUN 3 1947
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

486

04318

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Green AnneCity or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County 9 A.City or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary J. Chambers

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Oscar Chambers

7. Birth date of deceased (mo., day, yr.)

April 11 - 19006. (c) If alive, give age 52 years

8. AGE:

Years

Months

Days

If less than one day

470020

hrs.

min.

9. Birthplace

9 A. Co. Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Wm. W. Hiteley

13. Birthplace

Kent Co. Ind.

14. Maiden name

Mary A. Kirby

15. Birthplace

Kent Co. Ind.

16. Informant

Address

Dr. Oscar ChambersCenterville Ind.R.F.D.

17.

(Burial, cremation, or removal, which?)

Date thereof

May 4 - 1947

Cemetery or crematory

Chestertown

Location

Chestertown Ind.

18. Funeral director

Address

Agar R. LaneChurch Hill Ind.

19.

(Date rec'd by registrar)

May 3 1947Edgar R. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mary 15 1947, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15 - 1947 to May 12 1947and that I last saw him alive on May 10 1947

Immediate cause of death

Carcinoma of the

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. B. M. & R. Lane

M. D. or other

Address Centerville Ind. Date signed 5/2/47

MAINTAINING STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF ALABAMA

DEPARTMENT OF HEALTH

MAINTAINING STATE DEPARTMENT OF HEALTH

RECEIVED

MAY 9 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all her life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ida Rosetta Chilcutt

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mercedes Chilcutt

7. Birth date of deceased (mo., day, yr.)

March 1 - 1865

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

82214

_____ hrs.

_____ min.

9. Birthplace

Centerville, 2nd Co., Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Cahall

13. Birthplace

Queen Anne's Co., Md

MOTHER

14. Maiden name

Annie E. Pippin

15. Birthplace

Queen Anne's Co., Md

16. Informant

Mrs Katherine O'Neal

Address

Centerville Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 18-47
(month) (day) (year)

Cemetery or crematory

Chesterfield

Location

Centerville, Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

(Date rec'd by registrar)

19 47Elin Armstrong

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 14 19 47 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1946 19 46 to May 14 19 47and that I last saw him alive on May 7, 1947

Immediate cause of death

Chronic valvular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

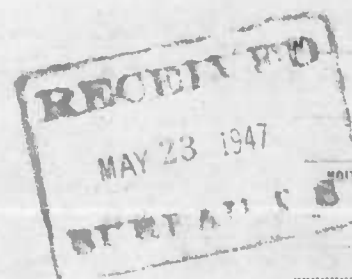
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. McPherson
M. D. or other
Address Centerville, Md Date signed 5/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04321

83a

Reg. Dist. No. 251

1. PLACE OF DEATH: *Queen Anne*
 County.....
 City or town *near Centerville*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *20 yr.*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *MD* County *Queen Anne*
 City or town *near Centerville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *James Luther Frazier*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *col* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *Hattie Frazier*
 6. (c) If alive, give age *57* years
 7. Birth date of deceased (mo., day, yr.) *Unknown 1889*

8. AGE: Years *about 62* Months *-* Days *-* If less than one day *-* hrs. *-* min.

9. Birthplace *Virginia*
 (Town, county, and state)
 10. Usual occupation *laborer*

11. Industry or business

12. Name *Don't know*

13. Birthplace *Don't know*

14. Maiden name *Don't know*

15. Birthplace *Don't know*

16. Informant *Gladys Roberts (Daughter)*
 Address *Centerville Md*

17. Burial (Burial, cremation, or removal). Which? *Burial* Date thereof *May 14-1947*
 (month) (day) (year)
 Cemetery or crematory *Centerville Ind.*
 Location *Edgar L. Lane*

18. Funeral director *Edgar L. Lane*
 Address *Centerville Ind.*

19. *May 14* 19 *47* *Edgar L. Lane*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 12* 19 *47* at *8 a* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 1* 19 *47* to *May 12* 19 *47*
 and that I last saw him alive on *May 12* 19 *47*

Immediate cause of death *Cerebral Hemorrhage*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. Henry Frazier*
 Address *Centerville Md* M. D. or other
 Date signed *5/14-47*

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. OCCASION OF DEATH

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MAY 24 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04320
213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

Colored

Widow.

6. (b) Name of husband or wife

none.

7. Birth date of deceased (mo., day, yr.)

mar 13 1961

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

.....hrs.min.

9. Birthplace

Stevensville Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Edward Jobs

FATHER

12. Name

Olley Green

13. Birthplace

Md.

MOTHER

14. Maiden name

Md.

15. Birthplace

Adena Gray

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 7, 1947
(month) (day) (year)

Cemetery or crematory

Cemetary

Location

Stevensville Md.

18. Funeral director

Address

Lewis A. Henry

Cambridge Md.

19.

(Date rec'd by registrar)

19.

47

Elizabeth Hooper

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4. 1947. at 10:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12th 1947 to May 4th 1947

and that I last saw him alive on May 4th 1947.

Immediate cause of death

Intestinal neoplasm
(chronic)
arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Doctor Sattelmair M.D. or other

Address Stevensville Date signed 5/7/47

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MAY 14 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Queen Anne's
 City or town... in Puthsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60+ years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Queen Anne's
 City or town... P.O. Queen Anne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... No

3. (a) FULL NAME

William Linwood Mason

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Elyaheth Fountain

7. Birth date of deceased (mo., day, yr.)

January 4 - 1859

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

88

4

16

.....hrs.

.....min.

9. Birthplace

in Puthsburg, Caroline Co. Md
 (town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

John Henry Mason

13. Birthplace

Caroline Co. Maryland

MOTHER

14. Maiden name

Nancy Pippin

15. Birthplace

Caroline Co Maryland

16. Informant

Norman Mason

Address

Queen Anne's Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 24 - 47
 (month) (day) (year)

Cemetery or crematory

Chestersfield

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

May 22 - 19 24
 (Date rec'd by registrar)

Elaine Armstrong
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 19 47, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

free 19 44 to May 20 19 47

and that I last saw him alive on May 18 19 47

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. J. M. H. M.
 Address Centerville, Md Date signed 6/22/47

88-47

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STANDARD INFORMATION

STANDARD INFORMATION

STANDARD INFORMATION

STANDARD INFORMATION

STANDARD INFORMATION

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JUN 4 1947
BUREAU 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04323

Reg. Dist. No. 254

1. PLACE OF DEATH:

County... Queen Anne
 City or town... Queenstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Queen Anne
 City or town... Queenstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hazel Scott

3. (b) Social Security Number

4. Sex 5. Color or race 6. (d) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 1 - 19138. AGE: Year 33 Months 7 Days - If less than one day hrs. min.9. Birthplace Centerville Rural MD
(Town, county, and state)10. Usual occupation Factory work11. Industry or business Owner12. Name Emmanuel C. Scott13. Birthplace Grassville MD14. Maiden name Ada Hazeltrap15. Birthplace Parmuchall Mt.16. Informant Ada ScottAddress Centerville Rural, MD.17. Burial Date thereof May 5, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Cherryfield CemeteryLocation Centerville, MD.18. Funeral director John D. McFarlandAddress Centerville MD19. May 2, 1947 Walter M. Gedridge
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 1st 1947 at 2 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to April 1947and that I last saw him alive on April 1947Immediate cause of death Tuberculosis, peritoneal

DURATION

10 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Tuberculosis PeritonealDate of op. Nov. 15, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Lane, MDAddress Queenstown MD Date signed May 1, 1947

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MAY 6 1947

SERIAL 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

123

04324

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County... Green AnneCity or town... near Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind. County... Green AnneCity or town... near Millington
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin Franklin Taylor

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Lula M. Taylor

6. (c) If alive, give age

72 years

7. Birth date of

deceased (mo., day, yr.)

Aug. 5 - 1873

8. AGE:

Years

Months

Days

If less than one day

7398

.....hrs.min.

9. Birthplace

Green Anne Co. Ind.

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

FATHER

12. Name

B. F. Taylor

13. Birthplace

Maryland

MOTHER

14. Maiden name

Anna Skinner

15. Birthplace

Maryland

16. Informant

Mrs. Lula Taylor

Address

Millington, Ind. R.F.D.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 16 - 1947
(month) (day) (year)

Cemetery or crematory

Church Hill

Location

Church Hill IndEdgar L. Lane

18. Funeral director

Address

Church Hill Ind.

19.

(Date rec'd by registrar)

19. 47

Edgar L. Lane
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 9 1947 to May 13 1947and that I last saw her alive on May 13 1947Immediate cause of death Hyperbacteria andParalysis of Bowels

DURATION

4 days

Due to

Hyperbacteria3 1/2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. B. Cephus

M. D. or other

Address

Millington, Ind.

Date signed

May 14, 47

RECEIVED TO THE DIRECTOR OF HEALTH

RECEIVED TO THE DIRECTOR OF HEALTH

RECEIVED

MAY 24 1947

BUREAU V S